

**ERIE COUNTY DEPARTMENT OF MENTAL HEALTH  
SPECIALTY SUPPORTED HOUSING PROGRAM  
DISABILITY VERIFICATION**

**Applicant's Name:** \_\_\_\_\_ **Date of Referral:** \_\_\_\_\_

Primary Disabling Diagnosis		
Axis	Code	Diagnosis

To be considered an eligible adult with a disability, **all criteria in Section A must be met.** In addition, criteria in **B OR C** must be met. A signature from a **licensed/credentialed psychiatric or medical professional** trained to make this determination is required for placement consideration.

**A. Designated Disability**

- ☐ Yes ☐ No The individual is 18 years of age or older and has a primary mental and/or physical diagnosis related to this specialty program which is expected to be of a prolonged and indefinite duration AND substantially impedes the applicant's ability to live independently; **AND**
- ☐ Yes ☐ No The applicant is medically/psychiatrically stable and poses no immediate potential or likelihood of harm to self or others; **AND**
- ☐ Yes ☐ No Is capable of maintaining a household and managing independent living (paying rent, meeting nutritional, medical and mental health needs) with housing case management and support provided;
- ☐ Monthly ☐ Weekly  
☐ Bi-weekly ☐ More than once a week

**AND**

**B. Extended Impairment in Functioning due to Disability**

The individual must meet **1** or **2** below:

- 1.** The individual has experienced *two of the following four* functional limitations *due to a designated disability over the past 12 months* on a continuous or intermittent basis.

- ☐ Yes ☐ No a. Marked difficulties in self-care
- ☐ Yes ☐ No b. Marked restriction of activities of daily living
- ☐ Yes ☐ No c. Marked difficulties in maintaining social functioning
- ☐ Yes ☐ No d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home or school settings.

**OR**

- ☐ Yes ☐ No **2.** The individual has met criteria for rating of *50 or less* on the Global Assessment of Functioning Scale.

**OR**

**C. Reliance on Psychiatric Treatment, Rehabilitation and Supports**

- ☐ Yes ☐ No A documented history shows that the individual, at some prior time, met the threshold for B (above) but symptoms and/or functioning problems are currently attenuated by medication or other rehabilitation and supports and without these continued supports the individual would be unable to sustain independent community living.

➤ **Signature of Professional making this determination (must include credentials and title):**

X \_\_\_\_\_

Date: \_\_\_\_\_

Title: \_\_\_\_\_

**ERIE COUNTY DEPARTMENT OF MENTAL HEALTH  
SPECIALTY SUPPORTED HOUSING PROGRAM  
HUD HOMELESS VERIFICATION  
(Required for applicants to HUD Homeless Programs Only)**

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Applicant's Name: \_\_\_\_\_

Date of Referral: \_\_\_\_\_

**Section A (at a minimum one of the criteria in section A must be met at the time of admission)**

- ☐ Yes ☐ No At the time of the referral and admission, lacks a fixed, regular and adequate night time residence and lives in one of the following:
- ☐ In places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, or the streets
  - ☐ A supervised public or private emergency/temporary shelter (not transitional housing)
  - ☐ Transitional/supportive housing program for homeless individuals or welfare hotels
  - ☐ Hospital or other institution for thirty (30) days or less and was homeless upon admission to the hospital or other institution

**(Note for Housing Providers: The following criteria are not applicable to HUD grants initiated or starting renewal periods on or after 1/1/2006. After this date only Transitional Housing programs may use this criteria)**

- ☐ Facing eviction within one week (provide copy of eviction notice) and does not have the resources to obtain new housing
- ☐ Discharge within a week from an institution in which the person has been a resident for 30 or more consecutive days and no subsequent residence has been identified and he/she lacks the resources and support networks needed to obtain housing.
- ☐ Other homeless situation, describe: \_\_\_\_\_

**Section B. Chronic Homeless Determination**

- ☐ Yes ☐ No Is the individual Chronically Homeless as defined by the following:
- ☐ Is 18 years or old and is an unaccompanied homeless individual (a single person who is alone. The individual is not part of a homeless family and/or is not accompanied by a child or children)  
**AND one of the following:**
    - ☐ Has been continuously homeless via living in the streets or shelters for a year or more
    - OR;**
    - ☐ Has had at least 4 episodes of homelessness in the past three (3) years.

**NOTE:** Chronically Homeless disabled individuals must have resided on the street or in emergency shelter only (not transitional housing) during the stays prior to admission

Person Completing Form: \_\_\_\_\_

Date: \_\_\_\_\_

**ERIE COUNTY DEPARTMENT OF MENTAL HEALTH  
SPECIALTY SUPPORTED HOUSING PROGRAM  
HUD HOMELESS VERIFICATION**

Federally funded HUD Homeless programs require additional written verification of homelessness. Therefore, if the applicant is seeking admission to one of the homeless housing programs based on their current homelessness status, the referral source must attach the form of written documentation that is described below for the category of homelessness claimed by the applicant. Applicants for OMH/ECDMH funded housing need not complete this verification.

**Written verification should be obtained from a reliable third party. Self-report statements are only acceptable if no other form of third party verification is obtainable.** Housing providers must insure that documentation reflects homeless status at the time of admission and therefore may need to update verification.

Verification is being provided that certifies the individual is homeless at the time of (check one):

☐ Referral Application

OR

☐ Admission

Check one	Category of Homelessness	Verification Required
	Living on street or other places not meant for human habitation	Signed and dated certification from an outreach worker or other third party verifying the individual resided on the street or other places not meant for human habitation immediately prior to admission
	Coming from an emergency shelter for homeless persons	Written referral from the emergency/temporary shelter verifying dates of stay immediately prior to admission
	Discharged from transitional or supportive housing for homeless individuals or welfare hotels	Written verification including dates of program residency and homeless status prior to entry to the transitional/supportive program or welfare hotel
	Discharged from an institution with a length of stay of less than 31 days (i.e. hospital discharges)	Written verification of dates of stay from the institution staff verifying a length of stay less than 31 days immediately prior to this referral/housing admission, information on previous homelessness prior to the institution's admission, documentation of efforts to obtain alternative housing and lack of resources to obtain any other housing
<b>(Note for Housing Providers: The following criteria are <u>not applicable</u> to HUD grants initiated or starting renewal periods on or after 1/1/2006. After this date only Transitional Housing programs may use this criteria)</b>		
	Discharged from an institution with a length of stay of greater than 30 days	Written verification of dates of stay from the institution staff verifying a length of stay greater than 30 days immediately prior to this referral/housing admission, information on previous homelessness prior to the institution's admission, documentation of efforts to obtain alternative housing and lack of resources to obtain any other housing
	Person being evicted within 1-week	Written eviction from landlord or family and description of efforts to obtain alternative housing and lack of resources to obtain any other housing